		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037358

Facility Name: BRIDGEVIEW HEALTH CARE CENTER

Address: 8100 S. HARLEM AVE. (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (847) 679 - 8219 **Fax #** (847) 679 - 7377

IDPA ID Number: 36-3780344

Date of Initial License for Current Owners: 10/02/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT			x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.				Individual		State
	Trust				Partnership		County
IRS Exemption Code					Corporation		Other
				x	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	146	TOTALS	146	53,290	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,984	1,984	8
9	SNF/PED					9
10	ICF	31,816	11,219		43,035	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,816	11,219	1,984	45,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.48%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/02/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/02/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 1,637

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	185,198	34,592	7,255	227,045		227,045	0	227,045			1
2	Food Purchase		259,376		259,376	(43,526)	215,850	(7,304)	208,546			2
3	Housekeeping	109,893	37,125	0	147,018		147,018	0	147,018			3
4	Laundry	62,775	13,230	2,376	78,381		78,381	0	78,381			4
5	Heat and Other Utilities			89,923	89,923		89,923	825	90,748			5
6	Maintenance	68,487	13,037	14,281	95,805		95,805	11,744	107,549			6
7	Other (specify):*			9,015	9,015		9,015	1,256	10,271			7
8	**TOTAL General Services**	426,353	357,360	122,850	906,563	(43,526)	863,037	6,521	869,558			8
	B. Health Care and Programs											
9	Medical Director	0		2,100	2,100		2,100	0	2,100			9
10	Nursing and Medical Records	1,782,496	54,947	169,802	2,007,245		2,007,245	45,852	2,053,097			10
10a	Therapy	0	1,128	5,781	6,909		6,909	0	6,909			10a
11	Activities	126,302	9,059	2,408	137,769		137,769	0	137,769			11
12	Social Services	45,860		1,718	47,578		47,578	0	47,578			12
13	Nurse Aide Training			0	0		0	129	129			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	3,924	3,924			15
16	**TOTAL Health Care and Programs**	1,954,658	65,134	181,809	2,201,601	0	2,201,601	49,905	2,251,506			16
	C. General Administration											
17	Administrative	63,761		153,495	217,256		217,256	(39,658)	177,598			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			40,191	40,191		40,191	12,729	52,920			19
20	Dues, Fees, Subscriptions & Promotions			34,378	34,378		34,378	(22,215)	12,163			20
21	Clerical & General Office Expenses	136,838	21,813	208,547	367,198		367,198	(135,712)	231,486			21
22	Employee Benefits & Payroll Taxes			513,465	513,465	43,526	556,991	0	556,991			22
23	Inservice Training & Education			4,285	4,285		4,285	0	4,285			23
24	Travel and Seminar			0	0		0	920	920			24
25	Other Admin. Staff Transportation			7,381	7,381		7,381	117	7,498			25
26	Insurance-Prop.Liab.Malpractice			112,752	112,752		112,752	3,718	116,470			26
27	Other (specify):*			0	0		0	19,256	19,256			27
28	**TOTAL General Administration**	200,599	21,813	1,074,494	1,296,906	43,526	1,340,432	(160,845)	1,179,587			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,581,610	444,307	1,379,153	4,405,070	0	4,405,070	(104,419)	4,300,651			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,102	26,102		26,102	166,561	192,663			30
31	Amortization of Pre-Op. & Org.				0		0	44,385	44,385			31
32	Interest			2,440	2,440		2,440	393,752	396,192			32
33	Real Estate Taxes			184,631	184,631		184,631	1,944	186,575			33
34	Rent-Facility & Grounds			498,620	498,620		498,620	(498,620)	0			34
35	Rent-Equipment & Vehicles			7,578	7,578		7,578	7,958	15,536			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			719,371	719,371	0	719,371	115,980	835,351			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		43,576	55,875	99,451		99,451	(2,317)	97,134			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			79,935	79,935		79,935	0	79,935			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	43,576	135,810	179,386	0	179,386	(2,317)	177,069			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,581,610	487,883	2,234,334	5,303,827	0	5,303,827	9,244	5,313,071			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,357	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(5,603)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,701)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(5,621)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(292)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(17,722)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	2,368			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,214)		$ 0	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	32,458		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 32,458		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 9,244		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BRIDGEVIEW HEALTH CARE CENTER

ID# 0037358

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2368	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	2,368		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,304)	0	0	0	0	0	0	0	0	0	0	(7,304)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	825	0	0	0	0	0	0	0	0	825	5
6	Maintenance	2,368	0	4,276	5,100	0	0	0	0	0	0	0	11,744	6
7	Other (specify):*	0	0	883	0	373	0	0	0	0	0	0	1,256	7
8	**TOTAL General Services**	(4,936)	0	5,984	5,100	373	0	0	0	0	0	0	6,521	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	45,894	0	(42)	0	0	0	0	0	45,852	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	129	0	0	0	0	0	0	0	0	129	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	3,924	0	0	0	0	0	0	3,924	15
16	**TOTAL Health Care and Programs**	0	0	129	45,894	3,924	(42)	0	0	0	0	0	49,905	16
	C. General Administration													
17	Administrative	0	(153,495)	0	113,837	0	0	0	0	0	0	0	(39,658)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(292)	11,164	1,857	0	0	0	0	0	0	0	0	12,729	19
20	Fees, Subscriptions & Promotions	(23,343)	0	1,128	0	0	0	0	0	0	0	0	(22,215)	20
21	Clerical & General Office Expenses	0	(186,640)	45,918	5,010	0	0	0	0	0	0	0	(135,712)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	920	0	0	0	0	0	0	0	0	920	24
25	Other Admin. Staff Transportation	0	0	117	0	0	0	0	0	0	0	0	117	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,718	0	0	0	0	0	0	0	0	3,718	26
27	Other (specify):*	0	0	7,405	0	11,851	0	0	0	0	0	0	19,256	27
28	**TOTAL General Administration**	(23,635)	(328,971)	61,063	118,847	11,851	0	0	0	0	0	0	(160,845)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,571)	(328,971)	67,176	169,841	16,148	(42)	0	0	0	0	0	(104,419)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,357	157,706	3,498	0	0	0	0	0	0	0	0	166,561	30
31	Amortization of Pre-Op. & Org.	0	44,385	0	0	0	0	0	0	0	0	0	44,385	31
32	Interest	0	391,751	2,001	0	0	0	0	0	0	0	0	393,752	32
33	Real Estate Taxes	0	0	1,944	0	0	0	0	0	0	0	0	1,944	33
34	Rent-Facility & Grounds	0	(498,620)	0	0	0	0	0	0	0	0	0	(498,620)	34
35	Rent-Equipment & Vehicles	0	0	7,958	0	0	0	0	0	0	0	0	7,958	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,357	95,222	15,401	0	0	0	0	0	0	0	0	115,980	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(2,317)	0	0	0	0	0	(2,317)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(2,317)	0	0	0	0	0	(2,317)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,214)	(233,749)	82,577	169,841	16,148	(2,359)	0	0	0	0	0	9,244	45

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 153,495	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (153,495)	1
2	V	21	BOOKKEEPING FEES	186,640	" "			(186,640)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V	34	RENT	498,620	BRIDGEVIEW ASSOCIATES			(498,620)	8
9	V	30	DEPRECIATION		" "		157,706	157,706	9
10	V	31	AMORTIZATION		" "		44,385	44,385	10
11	V	32	INTEREST		" "		391,751	391,751	11
12	V	19	ACCOUNTING & LEGAL FEES		" "		11,164	11,164	12
13	V								13
14	Total			$ 838,755			$ 605,006	$ * (233,749)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 825	$ 825	15
16	V	6	REPAIRS & MAINT.		" " "	100.00%	4,276	4,276	16
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	883	883	17
18	V	13	NURSES AIDE TRAINING		" " "	100.00%	129	129	18
19	V	19	PROFESSIONAL FEES		" " "	100.00%	1,857	1,857	19
20	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	1,128	1,128	20
21	V	21	CLERICAL & GENERAL		" " "	100.00%	45,918	45,918	21
22	V	24	SEMINARS AND TRAVEL		" " "	100.00%	920	920	22
23	V	25	ADMIN. STAFF TRANS		" " "	100.00%	117	117	23
24	V	26	INSURANCE		" " "	100.00%	3,718	3,718	24
25	V	27	EMP BEN. - GEN ADMIN.		" " "	100.00%	7,405	7,405	25
26	V	30	DEPRECIATION		" " "	100.00%	3,498	3,498	26
27	V	32	INTEREST		" " "	100.00%	2,001	2,001	27
28	V	33	REAL ESTATE TAXES		" " "	100.00%	1,944	1,944	28
29	V	35	EQUIPMENT RENTAL		" " "	100.00%	7,958	7,958	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 82,577	$ * 82,577	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 5,100	$ 5,100	15
16	V	10	NURSING CMP - SUE G.		" " "	100.00%	45,894	45,894	16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	31,706	31,706	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	42,775	42,775	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%			21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	10,290	10,290	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	11,098	11,098	25
26	V	17	ADMIN. CMP. - H. ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	17,968	17,968	27
28	V	21	CLERICAL CMP. - S. AARON		" " "	100.00%	5,010	5,010	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 169,841	$ * 169,841	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 373	$ 373	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%	3,924	3,924	16
17	V	27	EMP. BEN. - M. MAUER		" " "	100.00%	2,024	2,024	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	2,949	2,949	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	2,214	2,214	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,541	1,541	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	2,451	2,451	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	672	672	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 16,148	$ * 16,148	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 5,781	DYNAMIC REHAB CONSULTANTS LLC		$ 5,781	$	15
16	V	22	EMPLOYEE BENEFITS		" " "				16
17	V	39	ANCILLARY SERVICES	48,555	" " "		48,555		17
18	V								18
19	V								19
20	V	10	NURSING & MEDICAL SUPP	7,747	PHARMCOR LLC		7,747		20
21	V	19	PROFESSIONAL FEES		" "				21
22	V	21	CLERICAL & GENERAL	208	" "		208		22
23	V	22	EMPLOYEE BENEFITS		" "				23
24	V	39	ANCILLARY EXPENSE	22,436	" "		22,436		24
25	V								25
26	V								26
27	V	10	MEDICAL SUPPLIES	201	LINCOLN MEDICAL SUPPLIES, INC.		159	(42)	27
28	V	39	ANCILLARY EXPENSE	11,193	" " "		8,876	(2,317)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,121			$ 93,762	$ * (2,359)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MARSHALL MAUER		ADMINISTRATI					SALARY	$ 31,706	17-7	1
2	MAURY AARON		ADMINISTRATI		SCHEDULE ATTACHED			SALARY	45,894	17-7	2
3	SHARON AARON		CLERICAL					SALARY	5,010	21-7	3
4			ADMINISTRATI								4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,610		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	577,359	14	$ 10,580	$	45,019	$ 825	1
2	6	REPAIRS & MAINT	" "	577,539	14	54,834	37,633	45,019	4,276	2
3	7	EMP. BEN. - GEN. SVC.	" "	577,359	14	11,326		45,019	883	3
4	13	NURSES AIDE TRAINING	" "	577,359	14	1,650		45,019	129	4
5	19	PROFESSIONAL FEES	" "	577,359	14	23,811		45,019	1,857	5
6	20	DUES & SUBSCRIPTIONS	" "	577,359	14	14,469		45,019	1,128	6
7	21	CLERICAL & GENERAL	" "	577,359	14	588,891	487,646	45,019	45,918	7
8	24	SEMINARS & TRAVEL	" "	577,359	14	11,803		45,019	920	8
9	25	ADMIN. STAFF TRANS.	" "	577,359	14	1,502		45,019	117	9
10	26	INSURANCE	" "	577,359	14	47,685		45,019	3,718	10
11	27	EMP.BEN. - GEN. ADMIN.	" "	577,359	14	94,969		45,019	7,405	11
12	30	DEPRECIATION	" "	577,359	14	44,866		45,019	3,498	12
13	32	INTEREST	" "	577,359	14	25,667		45,019	2,001	13
14	33	REAL ESTATE TAXES	" "	577,359	14	24,936		45,019	1,944	14
15	35	EQUIPMENT RENTAL	" "	577,359	14	102,054		45,019	7,958	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 82,577	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	$ 62,194	$ 62,194	3	$ 5,100	1
2	10	NURSING - SUE G	" "	40	1	45,894	45,894	40	45,894	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	13	398,821	398,821	3	31,706	3
4	17	ADMIN. CMP. - M. AARON	" "	45	12	521,536	521,536	4	42,775	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,700	191,700		0	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	50	3	161,003	161,003		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	45	8	71,993	71,993		0	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	8	81,938	81,938	6	10,290	8
9	17	ADMIN. CMP. - E. CASSON	" "	38	1	47,846	47,846		0	9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	3	96,858	96,858		0	10
11	17	ADMIN. CMP. - S. LEVY	" "	55	13	139,807	139,807	4	11,098	11
12	17	ADMIN. CMP. -H. ALTER	" "	40	1	9,000	9,000		0	12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	13	219,069	219,069	4	17,968	13
14	21	CLERICAL CMP. - S. AARON	" "	40	13	63,022	63,022	3	5,010	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,681		$ 169,841	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
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Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	12	$ 4,545	$	3	$ 373	1
2	15	EMP BEN - SUE G.	" "	40	1	3,924		40	3,924	2
3	27	EMP BEN - M. MAUER	" "	40	13	25,461		3	2,024	3
4	27	EMP BEN - M. AARON	" "	45	12	35,957		4	2,949	4
5	27	EMP BEN - F. AARON	" "	45	6	22,028			0	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	20,193			0	6
7	27	EMP BEN - S. KOPLIN	" "	45	8	16,504			0	7
8	27	EMP BEN - D. MAGAFAS	" "	45	8	17,632		6	2,214	8
9	27	EMP BEN - E. CASSON	" "	38	1	11,976			0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	3	6,849			0	10
11	27	EMP BEN - S. LEVY	" "	55	13	19,408		4	1,541	11
12	27	EMP BEN - H. ALTER	" "	40	1	1,068			0	12
13	27	EMP BEN - NON-OWNER	" "	45	13	29,449		4	2,415	13
14	27	EMP BEN - S. AARON	" "	40	13	8,457		3	672	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 16,112	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679 - 8219
Fax Number: (847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						5,781	2
3	22	EMPLOYEE BENEFITS	" "							3
4	39	ANCILLARY EXPENSE	" "						48,555	4
5										5
6										6
7		PHARCOR LLC								7
8	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						7,747	8
9	21	CLERICAL & GENERAL	" "						208	9
10	22	EMPLOYEE BENEFITS	" "							10
11	39	ANCILLARY EXPENSE							22,436	11
12										12
13										13
14		LINCOLN MEDICAL SUPPLIES								14
15	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						159	15
16	39	ANCILLARY EXPENSE	" "						8,876	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 93,762	25

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LASALLE BANK		X	MORTGAGE	$45,250.00	06/30/95	$ 5,250,000	$ 0	06/30/05	8.4000	$ 172,679	1
2	CAMBRIDGE		X	MORTGAGE	$54,580.85	7/01	5,722,000	5,705,814			219,071	2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				325,000		PRIME +	2,440	6
7												7
8												8
9	TOTAL Facility Related				$99,830.85		$ 10,972,000	$ 6,030,814			$ 394,190	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 10,972,000	$ 6,030,814			$ 394,190	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	176,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	177,631	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,631	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	183,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	184,631	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	169,230	8
	1997	171,966	9
	1998	175,735	10
	1999	170,762	11
	2000	177,631	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRIDGEVIEW HEALTH CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0037358

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-214-061-00000	NURSING HOME	$ 177,630.29	$ 177,630.29
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 177,630.29	$ 177,630.29

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,560 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 304,000	1
2					2
3	TOTALS			$ 304,000	3

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		1995		$ 5,092,000	$ 130,559	39	$ 130,559	$	$ 928,634	4
5											5
6											6
7											7
8					34,589	887	35	988	101	8,235	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1991	1,017	32	31.5	32		327	9
10	LEASEHOLD IMPROVEMENTS			1991	2,715	181	15	181		1,848	10
11	LEASEHOLD IMPROVEMENTS			1992	85,574	2,718	31.5	2,718		26,955	11
12	LEASEHOLD IMPROVEMENTS			1993	1,600	51	31.5	51		444	12
13	LEASEHOLD IMPROVEMENTS			1994	8,141	209	39	209		1,571	13
14	1ST FLOOR CENTRAL A/C			1995	1,250	32	39	32		201	14
15	CARPET INSTALL			1995	1,303	33	39	33		205	15
16	RAIL BUMPER			1995	917	24	39	24		145	16
17	INSTALL PRESSURE CONTROL, LOCK & ALARM			1996	5,320	136	39	136		765	17
18	PAINTING WORK			1996	8,400	215	39	215		1,156	18
19	WALL COVERING			1996	1,435	37	39	37		196	19
20	FRONT LOBBY/WINDOW,DOOR WORK			1997	2,509	65	39	65		285	20
21	ELEVATOR REPAIR			1998	2,800	72	39	72		279	21
22	CONDENCING UNIT			1999	3,824	98	39	98		260	22
23	DRAPES			1999	5,369	138	39	138		330	23
24	CARPETING AND VINYL FLOORING			1999	8,540	219	39	219		543	24
25	DOOR WORK			1999	10,490	269	39	269		630	25
26	KITCHEN CABINETS			1999	5,832	150	39	150		369	26
27	TILES			2000	8,855	322	27.5	322		458	27
28	ELEVATOR REPAIR			2000	4,240	153	27.5	154	1	132	28
29	ROD MAIN SEWER			2000	1,100	40	27.5	40		58	29
30	DRAPERIES			2001	2,118	303	7	303		303	30
31	COVE BASE, BORDERS			2001	15,400	70	27.5	70		70	31
32	OVERHEAD FIXTURES			2001	6,411	10	27.5	10		10	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,321,749	$ 137,023		$ 137,125	$ 102	$ 974,409	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 213,709	$ 19,037	$ 21,282	$ 2,245		$ 121,019	71
72	Current Year Purchases	10,404	1,487	520	(967)		520	72
73	Fully Depreciated Assets				0			73
74	RELATED PAPRTY	324,542	29,520	32,360	2,840			74
75	TOTALS	$ 548,655	$ 50,044	$ 54,162	$ 4,118		$ 121,539	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	NURSING, HSKNG, MAIN	1991 DODGE VAN	1991	$ 24,971	$	$	$ 0	4 YRS	$ 24,971	76
77	RELATED PARTY			4,390	239	1,376	1,137		1,582	77
78							0			78
79							0			79
80	TOTALS			$ 29,361	$ 239	$ 1,376	$ 1,137		$ 26,553	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,203,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 187,306	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,663	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,357	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,122,501	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,808 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2000 GMC JIMMY	$ 489.00	$ 5,873	17
18	PAYROLL DEDUCTION			(3,103)	18
19					19
20					20
21	TOTAL		$ 489.00	$ 2,770	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests		129		129
9	TOTALS	$ 0	$ 129	$ 0	$ 129
10	SUM OF line 9, col. 1 and 2 (e)	$ 129			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 20,011	$		$ 20,011	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			352			352	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			28,863			28,863	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				31,390		31,390	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Med Supp, Lab, Rentals Other (specify):	39-2 & 3					18,835		18,835	13
14	TOTAL			$		$ 49,226	$ 50,225		$ 99,451	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 293,507	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	702,385		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,213		6
7	Other Prepaid Expenses	23,428		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): RE TAX ESCROW	88,871		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,152,404	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	195,154		15
16	Equipment, at Historical Cost	249,084		16
17	Accumulated Depreciation (book methods)	(238,917)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	527,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 732,821	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,885,225	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 444,116	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	325,000		29
30	Accrued Salaries Payable	283,352		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,233		31
32	Accrued Real Estate Taxes(Sch.IX-B)	183,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,246,701	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,246,701	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 638,524	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,885,225	$ 0	48

***(See instructions.)**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 892,635	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(2,113)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 890,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(130,398)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(121,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (251,998)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 638,524	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,134,192	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,134,192	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	30,708	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 30,708	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,926	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,926	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	5,603	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,603	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,173,429	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	906,563	31
32	Health Care	2,201,601	32
33	General Administration	1,296,906	33
	B. Capital Expense		
34	Ownership	719,371	34
	C. Ancillary Expense		
35	Special Cost Centers	99,451	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,303,827	40
41	**Income before Income Taxes (line 30 minus line 40)****	(130,398)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (130,398)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,853	2,175	$ 62,755	$ 28.85	1
2	Assistant Director of Nursing	1,797	2,106	56,570	26.86	2
3	Registered Nurses	10,707	12,227	243,654	19.93	3
4	Licensed Practical Nurses	22,454	26,150	469,610	17.96	4
5	Nurse Aides & Orderlies	79,488	87,933	796,250	9.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,482	3,825	50,559	13.22	9
10	Activity Assistants	9,014	9,973	75,743	7.59	10
11	Social Service Workers	3,499	3,957	45,860	11.59	11
12	Dietician					12
13	Food Service Supervisor	2,910	3,408	43,575	12.79	13
14	Head Cook	6,064	6,670	51,544	7.73	14
15	Cook Helpers/Assistants	13,218	14,059	90,079	6.41	15
16	Dishwashers					16
17	Maintenance Workers	3,818	4,332	68,487	15.81	17
18	Housekeepers	14,753	16,181	109,893	6.79	18
19	Laundry	7,967	8,765	62,775	7.16	19
20	Administrator	2,037	2,368	63,761	26.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,399	11,040	136,838	12.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,718	4,262	78,317	18.38	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coor	3,782	4,481	75,340	16.81	33
34	TOTAL (lines 1 - 33)	199,960	223,912	$ 2,581,610 *	$ 11.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,252	1-3	35
36	Medical Director	O	2,100	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	1,264	10-3	38
39	Pharmacist Consultant	H	4,050	10-3	39
40	Physical Therapy Consultant	L	2,570	10a-3	40
41	Occupational Therapy Consultant	Y	3,190	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	21	10a-3	43
44	Activity Consultant	E	2,408	11-3	44
45	Social Service Consultant	E	1,718	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 23,573		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	616	$ 13,096	10-3	50
51	Licensed Practical Nurses	6,987	141,972	10-3	51
52	Nurse Aides	499	9,150	10-3	52
53	TOTAL (lines 50 - 52)	8,102	$ 164,218		53

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTHA PECK	ADMIN	0	$ 63,761
		0	0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,761

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 153,495
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 153,495

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEM	DATA PROCESSING	$ 2,846
IL COLLECTION SERVICES	COLLECTION	292
KRUPNICK, BOKOR	ACCOUNTING	17,442
SACHNOFF & WEAVER	LEGAL	3,987
LITTLER MENDELSON	LEGAL	791
FINKEL MARTWICK	LEGAL	3,418
PERSONNEL PLANNERS	UC CONSULTANT	1,107
ECONOCARE	PURCHASING CONSLT	2,700
DART CHART SYSTEM	MEDICARE CONSULT	7,608
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 40,191

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,779
Unemployment Compensation Insurance	14,418
FICA Taxes	196,700
Employee Health Insurance	239,484
Employee Meals	43,526
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	8,084
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 556,991

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,519
Health Care Worker Background Check	198
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	17,722
RELATED PARTY	1,128
CONTRIBUTIONS	5,621
DUES & SUBSCRIPTIONS	6,068
LICENSES & PERMITS	2,250
LESS CONTRIBUTIONS	(5,621)
Less: Public Relations Expense	(0)
Non-allowable advertising	(17,722)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,163

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
RELATED PARTY	920
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 920

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER # 0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING & DECORAT	1999	$ 4,058	3	$	$ 676	$ 1,353	$ 1,353	$ 676	$	$	$	$
2		2000	3,046	3			508	1,015	1,015	508			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,104		$	$ 676	$ 1,861	$ 2,368	$ 1,691	$ 508	$	$	$

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER **#** 0037358 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNC LONG TERM CARE - $6409**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **11,732** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **79,935**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **43,526** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BRIDGEVIEW HEALTH CARE CENTER #0037358 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,252	
	REPAIRS & MAINTENANCE		1,003	
			0	7,255
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,376	
			0	2,376
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		37,583	
	ELECTRICITY		38,752	
	WATER		13,588	
	CABLE TV - LOBBY		0	
			0	89,923
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,801	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,732	
	ELEVATOR MAINTENANCE & REPAIR		5,848	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,900	
	FIRE SERVICE		0	
			0	
			0	
			0	14,281
7	**OTHER**			
	SCAVENGER		9,015	
	SECURITY SERVICE		0	9,015
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,100	2,100

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	164,218	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,050	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	270	
	RN CONSULTANT	XVIII B 38-2	1,264	
			0	
			0	169,802
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,570	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,190	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	21	5,781
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,408	
			0	2,408
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,718	
			0	1,718
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BRIDGEVIEW HEALTH CARE CENTER **#0037358** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	153,495	153,495
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	2,846	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	37,053	
	ACCOUNT COLLECTION FEES		292	40,191
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	17,722	
	EMPLOYEE WANT ADS	XIX F	2,519	
	CONTRIBUTIONS	VI 20 XIX F	125	
	DUES & SUBSCRIPTIONS	XIX F	6,068	
	LICENSES & PERMITS	XIX F	2,250	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,496	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	198	34,378
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		73	
	EQUIPMENT REPAIR & MAINTENANCE		6,259	
	OUTSIDE CLERICAL SERVICES		186,640	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,575	
	MESSENGER SERVICE		0	
			0	208,547

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	196,700	
	UNEMPLOYMENT COMPENSATION	XIX D	14,418	
	WORKERS COMPENSATION INSURANC	XIX D	54,779	
	HOSPITALIZATION INSURANCE	XIX D	239,484	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,084	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	513,465
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,285	4,285
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,381	7,381
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		112,752	112,752
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,379,153

BRIDGEVIEW HEALTH CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	259,376
LESS SALES TAX	(1,701)
NET FOOD	257,675
TOTAL PATIENT CENSUS	45,019
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	135057
ADD # EMPLOYEE MEALS/DAY	75
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	27375

PATIENT MEALS	135057
ADD EMPLOYEE MEALS	27375
TOTAL MEALS/YEAR	162432
NET FOOD	257675
DIVIDE TOTAL MEALS/YEAR	162432
COST PER MEAL	1.59
TIME EMPLOYEE MEALS	27375
EMPLOYEE MEAL RECLASSIFICATION	43526